Lexington-Fayette Urban County Government: Healthcare Plan 1

Coverage Period: 01/01/2015 - 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-844-812-9209.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** Individual/**$1,000** Family for In-Network Providers. **$1,500** Individual/**$3,000** Family for Out-of-Network Providers. In-Network Provider and Out-of-Network Provider deductibles are separate and do not count towards each other.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$1,500** Individual/**$3,000** Family for In-Network Providers. **$4,500** Individual/**$9,000** Family for Out-of-Network Providers. In-Network Provider and Out-of-Network Provider out-of-pocket are separate and do not count towards each other.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Services deemed not medically necessary by Medical Management and/or Anthem, Penalties for non-compliance, Pharmacy claims, Premiums, Balance-billed charges and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Does this plan use a network of providers?	Yes. See www.anthem.com or call 1-844-812-9209 for a list of In-Network Providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$15** Copay/Visit	**50%** Coinsurance	--------none--------
	Specialist visit	**$30** Copay/Visit	**50%** Coinsurance	--------none--------
	Other practitioner office visit	Chiropractor **$15** Copay/Exam Acupuncturist Not Covered	Chiropractor **50%** Coinsurance Acupuncturist Not Covered	Chiropractor Coverage is limited to 20 visits maximum per Benefit Period combined In-Network and Out-of-Network Providers. Acupuncturist --------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No Cost Share	**50%** Coinsurance	Hearing Exam (Routine): $15 or $30 Copay per Visit for In-Network Providers. Immunizations - Child and Adult (Routine): Travel Immunizations are Not Covered for In-Network and Out-of-Network Providers. Vision Exam (Routine): Not Covered for In-Network and Out-of-Network Providers.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office **20%** Coinsurance X-Ray – Office **20%** Coinsurance	Lab – Office **50%** Coinsurance X-Ray – Office **50%** Coinsurance	Lab – Office Costs may vary by site of service. You should refer to your formal contract of coverage for details. Failure to obtain pre-certification may result in a late notice penalty of $300 applies for below services: Diagnosis of Sleep Disorders, Gene Expression Profiling for Managing Breast Cancer Treatment and Genetic Testing for Cancer Susceptibility. X-Ray – Office Costs may vary by site of service. You should refer to your formal contract of coverage for details. Failure to obtain pre-certification may result in a late notice penalty of $300 applies for below services: Diagnosis of Sleep Disorders, Gene Expression Profiling for Managing Breast Cancer Treatment and Genetic Testing for Cancer Susceptibility.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-certification may result in a late notice penalty of $300 applies for below service: MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Tier 1 - Typically Generic			
	Tier 2 - Typically Preferred/ Formulary Brand			
	Tier 3 - Typically Non-preferred/Non-Formulary Drugs			
	Tier 4 - Typically Specialty Drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**20%** Coinsurance	**50%** Coinsurance	--------none--------
	Physician/surgeon fees	**20%** Coinsurance	**50%** Coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	**20%** Coinsurance	**20%** Coinsurance	Failure to obtain pre-certification for Emergency Admissions (Requires Plan notification no later than 2 business days after admission) may result in a of $300.
	Emergency medical transportation	**20%** Coinsurance	**20%** Coinsurance	--------none--------
	Urgent care	**$60** Copay/Visit	**50%** Coinsurance	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-authorization may result in non coverage and $300 late notice penalty applies.
	Physician/surgeon fee	**20%** Coinsurance	**50%** Coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit **$15** Copay/Visit Mental/Behavioral Health Facility Visit – Facility Charges **20%** Coinsurance	Mental/Behavioral Health Office Visit **50%** Coinsurance Mental/Behavioral Health Facility Visit – Facility Charges **50%** Coinsurance	Mental/Behavioral Health Office Visit --------none-------- Mental/Behavioral Health Facility Visit – Facility Charges Failure to obtain pre-authorization may result in non coverage and $300 late notice penalty applies.
	Mental/Behavioral health inpatient services	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-authorization may result in non coverage and $300 late notice penalty applies.
	Substance use disorder outpatient services	Substance Abuse Office Visit **$15** Copay/Visit Substance Abuse Facility Visit – Facility Charges **20%** Coinsurance	Substance Abuse Office Visit **50%** Coinsurance Substance Abuse Facility Visit – Facility Charges **50%** Coinsurance	Substance Abuse Office Visit --------none-------- Substance Abuse Facility Visit – Facility Charges Failure to obtain pre-authorization may result in non coverage and $300 late notice penalty applies.
	Substance use disorder inpatient services	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-authorization may result in non coverage and $300 late notice penalty applies.
If you are pregnant	Prenatal and postnatal care	**$15** Copay/Visit	**50%** Coinsurance	Copay applies to office visit. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Delivery and all inpatient services	**20%** Coinsurance	**50%** Coinsurance	Failure to obtain pre-certification may result in a late notice penalty of $300 for childbirth if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery. Applies to inpatient facility. Other cost shares may apply depending on the services provided.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**20%** Coinsurance	**50%** Coinsurance	Coverage is limited to 100 visits maximum per Benefit Period combined In-Network and Out-of-Network Providers.
	Rehabilitation services	**20%** Coinsurance	**50%** Coinsurance	Coverage is limited to 45 visits per Benefit Period combined for Physical Therapy, Occupational Therapy, Cardiac Rehab, Speech Therapy, Cognitive and Audiology Therapies combined In-Network and Out-of-Network Providers.
	Habilitation services	**20%** Coinsurance	**50%** Coinsurance	Habilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	**20%** Coinsurance	**50%** Coinsurance	Coverage is limited to 60 days per Benefit Period combined In-Network and Out-of-Network Providers. Failure to obtain pre-authorization may result in non coverage and $300 late notice penalty applies.
	Durable medical equipment	**20%** Coinsurance	**20%** Coinsurance	Failure to obtain pre-authorization may result in non coverage and $300 late notice penalty applies.
	Hospice service	No Cost Share	No Cost Share	--------none--------
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	--------none--------
	Glasses	Not Covered	Not Covered	--------none--------
	Dental check-up	Not Covered	Not Covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric surgery • Dental care (Adult)	• Infertility treatment • Long-term care • Private-duty nursing	• Routine eye care (Adult) • Routine foot care (Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.) • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care • Cosmetic surgery	• Hearing aids (Coverage is limited to a maximum of one per Hearing impaired ear, once every three Benefit Period.)	• Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-844-812-9209. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Or Contact:

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform

Department of Insurance
215 West Main Street
Frankfort, Kentucky 40601
Main: 502-564-3630
Toll Free (Kentucky only): 800-595-6053
TTY: 800-648-6056

A consumer assistance program can help you file your appeal. Contact:
Kentucky Department of Insurance
Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602
(877) 587-7222
http://healthinsurancehelp.ky.gov
DOI.CAPOmbudsman@ky.gov

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídííłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki sí'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,870
- **Patient pays:** $1,670

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$170
Total	**$1,670**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,620
- **Patient pays:** $3,780

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$130
Coinsurance	$220
Limits or exclusions	$2,930
Total	**$3,780**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘**No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓**Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.